B. Eliot Cole, MD, MPA
9123 Fawn Grove Drive
Las Vegas, NV 89147-6810

August10, 2001

Re: September 13-14, 2001 Anesthetic and Life Support Drugs Advisory Committee meeting (docket number 01N-0256)

Kimberly Topper
Center for Drug Evaluation and Research (HFD-21)
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Topper:

There never were any "good old days" when we took care of patients living with chronic disabling painful conditions. There were tens of thousands of Americans who were endangered, forced to suffer needlessly and ultimately to seek out the services of Dr. Jack Kevorkian. We never want to go back to the "good old days."

For the past decade there has been an increasing acceptance and utilization of chronic opioid analgesic therapy for patients living with chronic pain. There has been federal interest in this topic as well evidenced by the former Agency for Health Care Policy and Research's clinical practice guidelines on acute, cancer and lower back pain. National pain organizations routinely publish criteria for proper patient selection, proper medication selection, best methods for the ongoing monitoring of opioid therapy and determining efficacy through measures of outcome. Rather than responding hysterically to the debate regarding opioid therapy for the management of chronic pain disorders pain practitioners in the United States have carefully linked evidence to their therapeutic decision-making.

All of this is now threatened because allegedly many people have died from overdoses related to OxyContin. If one believes what is printed in the popular press around 120 may have died (a number that never changes over time despite the intense media coverage). Closer inspection of this allegation suggests that the number of deaths attributable to OxyContin alone is doubtful at best if not outright fraudulent. Most of these individuals died with multiple substances in their blood. In his article, "The OxyCon Job," Sandeep Kaushik has attempted to learn the actual circumstances behind the "numbers" and says what many of us suspected, the numbers are made up. Nevertheless, Americans need

to be protected from their own actions. Hence the present need for the FDA to examine the question of chronic opioid analgesic therapy for pain control.

No one really disputes that opioid analgesics are not effective for the control of pain. No one disputes that chronic opioid analgesic therapy is far safer than many of the alternatives: aspirin, acetaminophen, nonsteroidal anti-inflammatory drugs, tricyclic antidepressants and others. There is no end organ toxicity with opioids except reversible suppression of testosterone levels in men and possible interference with lymphocyte rosette formation. Heart, liver, kidneys, lungs, stomach and spleen are all spared when opioids are used medicinally. We do not have a safer class of analgesics, or a more efficacious one. Aspirin and nonsteroidal anti-inflammatory agents eventually lead to gastrointestinal bleeding, interference with platelet function, liver and kidney toxicity, and lethal allergic reactions. Acetaminophen leads to liver and kidney toxicity. These potentially dangerous products are sold over the counter to the same Americans who now need to be protected by the FDA from their own self-endangering drug abuse behavior. They are allegedly crushing or chewing OxyContin to get immediate access to the oxycodone for the purposes of experimentation, excitation and intoxication. They are willing to literally die to get high.

What is the FDA to do? The FDA's mission is to "...promote the public health by promptly and efficiently reviewing clinical research and taking appropriate action on the marketing of regulated products in a timely manner." With respect to such products, the FDA is to protect the public health by ensuring that "...human and veterinary drugs are safe and effective." In doing so, the FDA is to "...participate through appropriate processes with representatives of other countries to reduce the burden of regulation, harmonize regulatory requirements, and achieve appropriate reciprocal arrangements." When appropriate, the FDA is to consult with "...experts in science, medicine, and public health, and in cooperation with consumers, users, manufacturers, importers, packers, distributors and retailers of regulated products."

To examine the OxyContin question, or the broader question of the appropriateness of chronic opioid analgesic therapy for pain disorders, the FDA must utilize the points articulated in the mission statement. Rather than react precipitously, as many justice/law enforcement agencies have done, the FDA must use science, expert opinion and acknowledge that opioid therapy for pain is a recent phenomenon that has changed the lives to the good for tens of thousand of Americans. The FDA must attempt to protect the rights of Americans with pain while it prevents inadvertent death by other Americans who are engaged in criminal activity. Clearly, public policy for the health, safety and welfare of patients living with intractable pain must not be sabotaged by the failure of the criminal justice system to catch and prosecute dishonest prescribers or end users of illicitly obtained lawful opioid products. To do less is to punish the patients for their lawful use of medication and to make them victims of those who have abused medications for their own intoxication.

Public policy is generally shaped by politics, funding levels and the popular press. Public policy as it relates to the long-term role of opioid analgesic therapy must be shaped around the practice of medicine. All therapies must be prescribed to patients in a safe and ethical fashion. All therapies must be thoroughly examined for their benefit-to-risk aspect, provision of informed consent, and with continuous monitoring for efficacy and long-term safety. The US Federation of State Medical Boards opioid guidelines for chronic pain, along with the guidelines promulgated by the American Medical Directors Association, American Geriatrics Society and the position statement of the American Pain Society and the American Academy of Pain Medicine (endorsed and adopted by the American Academy of Pain Management) are entirely consistent with this view. Organizations involved with the treatment of pain now universally support the role of opioid analgesic therapy for the long-term management of pain.

Law enforcement faces a difficult challenge. The "war on drugs" cannot be won with current efforts. At best illicit drug use for prescription agents can be slowed, but cannot ultimately be entirely stopped. Calls by the Drug Enforcement Agency to restrict the use of opioids for pain control goes beyond their sphere of authority and truly threatens the health, safety and welfare of the American people. Suggestions by the DEA to only allow certain types of physicians to prescribe Schedule II opioids is just bad public policy when one considers that 70% of primary care visits are motivated by pain. Only allowing pain specialists to prescribe "strong opioids" is unworkable when there are only about 5,000 such specialists in the US. Knee jerk law enforcement responses to attack the illicit diversion of lawful opioids while not addressing the underlying problem of substance abuse in our country cannot be successful. Level thinking, careful planning and multidisciplinary consensus are the best solutions.

Opioids are being rediscovered by the substance abusers of this country. Drug use comes and goes in cycles. We have seen the abuse of opioids come and go just like psychostimulants, hallucinogens and other substances. Unfortunately, we are seeing opioid abuse in general making a "come back" right now. The proper response for this or any other drug abuse is to focus on the behavior, not the product. Abusers must be either treated medically for their underlying disorder or punished for their criminal behavior. The products they abuse are not the issue; their behavior is the issue.

Cars kill thousands of Americans annually, but no one seriously considers banning automobiles or even redesigning them. We regulate firearms so certain people cannot easily obtain them, but we do not outright ban them. Nonsteroidal anti-inflammatory medications lead to the deaths of thousands of Americans annually, around 16,500 per year, but we do not ban them. Why would we outright try to ban opioids for the management of pain? Considering the fact that opioids represent the most highly regulated group of medications in the United States what else can practically be done? Should anything else be done?

When one considers that there may only have been 120 deaths related to OxyContin (a number that is not legally established since most of these individuals had multiple substances in their blood, including alcohol) perhaps we should acknowledge how well opioid analgesics have been prescribed and how incredibly safe they are. Unlike the current carnage from nonsteroidal agents, or the historical problems associated with barbiturates, the extremely low numbers of deaths seen with opioids suggests that something must be working. Minimally, proper medication and patient selection, better monitoring and the current regulatory processes must be working.

To best answer the questions regarding chronic opioid analgesic therapy the FDA might consider the following strategies:

Convene a multidisciplinary long-term opioid advisory committee (much like the process used by the Agency for Health Care Policy and Research pain related clinical practice guidelines) to review the current literature, clinical practices in America, and to ultimately draft federal guidelines. The major addiction, medical, nursing, pain management, pharmacy and psychology organizations should participate along with representatives of the Drug Enforcement Agency, Office of National Drug Control Policy, National Institute of Drug Abuse and patient advocacy/support groups (National Chronic Pain Outreach and the American Pain Foundation).

Utilize subpoena powers to obtain the medical records and death certificates of alleged OxyContin related deaths to determine what is actually occurring.

Promote further opioid education for physicians, pharmacists and nurses about proper medication and patient selection, best methods for ongoing compliance, determination of efficacy based upon measurable outcome.

Create an interagency task force with the Drug Enforcement Agency, Office of National Drug Control Policy and National Institute of Drug Abuse to promote coordinated federal efforts to realistically decrease the demand for illicit substances by Americans and to prevent sensationalism from dictating public policy.

Establish a pharmaceutical industry research and development committee to advise the manufacturers about technologies that might be employed to prevent or retard lawful medication abuse.

The FDA is charged with the responsibility of protecting the health, safety and welfare of the American people as it relates to pharmaceuticals. The actions listed above would do much to facilitate the FDA's mission.

We are at a crossroads. We can try to put the genie back in the bottle and stop using opioids to control pain or we can use our boundless resources to define appropriate patients for long-term opioid therapy, monitoring techniques and consensus based measures of outcome. Hopefully, reason will prevail and the

FDA can meaningfully use this present situation to craft good public policy for all Americans. We can promote pain relief for intractable pain sufferers while we maintain the public's health, safety and welfare.

We must define solutions for the problems we are facing. Pitting one vested interest against another will never lead to effective solutions or public policy. We must work together to make optimal therapies available for those who need them while responsibly preventing the medications from falling into the hands of people who have serious dependency disorders.

The American Academy of Pain Management advocates on behalf of pain sufferers and those who provide their care. The American Academy of Pain Management affirms its commitment to find meaningful solutions for the long-term relief of intractable pain and is prepared to assist the FDA in any way. The senior leadership of the American Academy of Pain Management offers its collective skill in education, medicine, psychology and public policy to the FDA.

Respectfully submitted,

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